TRICARE 102

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Overview

- Line of Duty
- Temporary Duty Retired List
  - Eligibility/Exams
- Dual Eligibility Patients
- ADSMs on Terminal Leave
- Supplemental Health Care Program
- TRICARE Billing

Line of Duty

Line of Duty (LOD)

Reserve and National Guard

- RC members on orders for 30 days or less are ineligible in DEERS
- Unit Commander or Service HQ determines LOD eligibility
- MMSO only authorizes Remote LOD care
  - TPR rules applied
- Non ER civilian LOD care must be pre-authorized by either an MTF or MMS

Line of Duty (LOD)

Reserve/National Guard

- RC have the same priority for access to MTF care as the AD for LOD injuries only (32 CFR 199.17, HA Policy 01-015)
  - Utilize MTF Patient Administration function for appointment assistance
- MTF provides direct care or authorizes civilian care referrals for members residing within MTF catchment
- MTF authorization should drive claim payment and bypass ineligibility in DEERS
  - Ensure all authorizations are submitted to the MCSCs (TOM Ch 18 Sec 3 para 1.2.3, 2.1, 2,2)
- MMSO only authorizes civilian care in remote areas

Line of Duty (LOD)

MMSO Contact Representatives

- Unit coordinates directly with MMSO contact reps/nurses
- Unit FAXES an “Authorization for care request” (MMSO Form 2) with supporting LOD eligibility documentation
- MMSO contact rep reviews, logs LOD in, does quality control
  - Insures LOD is complete and legible
  - Contacts unit rep for any questions
  - Once complete forwards to Nurse Consultants for final authorization

Line of Duty (LOD)

Nurse Consultants

- Review request to insure that documented injury matches diagnosis and tx plan
- May request additional clinical information
- NC will contact unit med rep if care needs to go to an MTF; travel time an hour or less or fitness for duty issues, LOD over 1 yr old w/ no tx.
- NC authorizes Episode of Care
- Internal MMSO authorization is communicated to unit within 5-7 working days (Current turnaround 1-2 working days)

Temporary Duty Retired List

Temporary Disability Retirement List (TDRL)

Eligibility

- DEERS documents TDRL members as retired
- Members on TDRL have retired benefits
- TDRL members pay to enroll in Prime and with the exception of service directed TDRL exams must pay co-pays or Standard/Extra deductibles and cost shares

Temporary Disability Retirement List (TDRL)

TDRL Exams/Treatment Referrals

- Requires authorization from MTF
- TDRL exam referral will process with Supplemental Health Care Program coverage. Process as ADSM
- No co-pays, cost shares or deductibles apply
- Referrals are for specialty consults only
- No Fitness for Duty Recommendations
- Complete specialty consult and provide report to MTF
- TDRL exam forms must be completed by MTF

Dual Eligibility

Dual Eligibility for TRICARE Patients

- Understand the difference between service-connected (SC) conditions and nonservice-connected (NSC) conditions and how it impacts the episode of care
- Explain how/why the veteran status is always the veteran's primary eligibility
- Advise patients of their eligibility options under both the VA health care program and TRICARE
- Advise patients of their financial liability
- Record the eligibility correctly
- If on active duty, then VA must register and treat as such

Dual Eligibility for TRICARE Patients

- SC conditions must be treated under veterans benefits (do not bill OHI)
- NSC conditions can be either treated under veteran or TRICARE benefits
  - Patient must choose for each episode of care
    - Does not apply to TRICARE for Life patients
  - VAMC must be a network provider to treat under TRICARE benefits
  - Once chosen the benefit, it applies to the entire episode of care

* NOTE: Episode of care generally refers one or more health care services received during a period of relatively continuous care by a hospital or health care provider

Dual Eligibility for TRICARE Patients

- OHI is billed primary and TRICARE secondary
  - Exception Medicaid, IHS, and state-sponsored medical programs
- TRICARE patients who have a choice between benefits should carefully evaluate the costs associated with each before deciding

- Reference: VHA CBO TRICARE Handbook

ADSMs on Terminal Leave

Authorization Process for Terminal Leave

- ADSMs residing outside of MTF PSA
  - VAMC will be closest medical facility
  - Single authorization from the last MTF
  - Routine or urgent outpatient care
- VAMC staff will need to:
  - Obtain a copy of military ID card
  - Check the TRICARE contractors website to validate authorization and end date

Authorization Process for Terminal Leave

- Emergent care
  - VAMC to contact TRICARE contractor for authorization as soon as possible after providing care
- Inpatient care is not included in the blanket authorization
  - Non-emergent requires pre-authorization
  - Emergency requires notification within 24 hours

Supplemental Health Care Program

Definition

Supplemental Health Care Program (SHCP)

- The SHCP provides for the payment by the uniformed services to private sector health care providers for health care services provided to active duty members of the uniformed services.

- Also applies to health care services covered under TRICARE when ordered by an MTF provider for an MTF inpatient (not AD) for whom the MTF maintains responsibility.

Authority for SHCP

- 10 USC 1074(c)
  - Medical or dental care "…other than elective private treatment"
    - Members of the uniformed services
  - Private sector facilities
  - Same payment rules as apply under TRICARE
- 32 CFR 199.16(a)(3)
  - Implements SHCP for active duty members and also authorizes use of SHCP for "health care services ordered by a military treatment facility for an MTF patient (who is not an active duty member) for whom the MTF provider maintains responsibility"
  - SHCP uses same payment rules, "subject to appropriate modifications," as apply under TRICARE
  - There is no patient cost sharing under SCHP

SHCP for Active Duty

- The SHCP provides for the payment by the uniformed services to private sector health care providers for health care services provided to active duty members of the uniformed services.

- Also applies to health care services covered under TRICARE when ordered by an MTF provider for an MTF inpatient (not AD) for whom the MTF maintains responsibility.

SHCP for Active Duty
Restrictions

- SHCP authorized:
  - Medical or dental care
  - "Clinically appropriate"
  - "Adequate availability of health care services"
- Guidance:
  - SHCP usually appropriate
    - Medically necessary care that is part of TRICARE benefit
  - SHCP may be appropriate
    - Care outside TRICARE benefit
  - SHCP may not be used
    - Care explicitly prohibited by statute or regulation

SHCP for Active Duty
Established Processes

- MTF Commander authorizes payment for AD beneficiaries receiving care in an MTF
- Military Medical Support Office (MMSO) authorizes payment for TRICARE Prime Remote active duty beneficiaries
  - No requirement to preauthorize primary care services that do not involve fitness for duty determinations, PRP, etc.
- Only Director, TMA may exercise discretionary authority to permit payment for any service

requiring a waiver

SHCP for Active Duty

Examples

- Appropriate use:
  - Anterior cruciate ligament repair
  - C-section
  - Coronary angioplasty
  - Tobacco cessation counseling and pharmacotherapy
  - Weight loss counseling and pharmacotherapy
- May be appropriate:
  - Refractive surgery for a war-fighter
  - Residential treatment for eating disorder
- Inappropriate use:
  - Sperm banking for testicular cancer patient
  - Sending a Sailor from US to a foreign country for non-FDA approved chemo clinical trial
  - Bariatric surgery for a Soldier
  - Chiropractic care
  - Cosmetic surgery
  - Phase I clinical trial
- Commander's discretion:
  - Elective correction of minor dermatological blemishes or minor anatomical anomalies

TRICARE Billing

TRICARE Overview –
Differences in Management of the TRICARE Program

The management of the TRICARE program involves the following differences.

- Veterans Information System Technology Architecture (VistA) files must contain the correct TRICARE entries.
- The cost of care versus the cost of reimbursement must be routinely evaluated for TRICARE patients.
- TRICARE contracts must be negotiated so as to ensure that revenue covers direct costs.
- The TRICARE program must be monitored at each Department of Veterans Affairs (VA) health care facility (HCF).

TRICARE Overview –
Differences in Management of the TRICARE Program

The management of the TRICARE program involves the following differences. (continuation)

- The Veterans Health Administration (VHA) Chief Business Office (CBO) must provide National Patient Identification (NPI) compact discs (CDs) to the TRICARE Managed Care Support Contractor (MCSC) with provider information.
- Veterans can have dual eligibility under multiple programs.
- There are different TRICARE programs (for example, TRICARE for Life (TFL)), each with its own set of benefits and restrictions.
- TRICARE may appear to function as a third party insurance, however, it is not a commercial insurance
  he plan provisions are different from a third
  er., as this is an entitlement, as determined

TRICARE Counseling Process

In order to have a *successful* TRICARE program, it is important to take time to sit with TRICARE patients and explain

- **all the processes and procedures associated with their care**
- **their financial responsibility to VA and TRICARE, and**
- **the importance of providing their other health insurance (OHI).**

More specifically, when TRICARE patients first register for an episode of care, their benefits will be different if they are dual eligible. Intake staff or *dedicated VA/DoD/ TRICARE staff* should discuss

- **TRICARE eligibility; dual eligibility (financial responsibilities as a veteran versus TRICARE and the selection of benefits for each episode of care)**
  - **benefits versus VA benefits**
  - **sponsibility for cost shares, including**
  - **s and/or deductible (*Note*: *VA is not allowed***

TRICARE Counseling Process

Continuation

- **Assignment and role of the VA Primary Care Manager (PCM) versus non-VA PCM, if appropriate**
- **TRICARE referral and authorization process**
- **Release of medical/health information (ROI), if applicable**
- **Check-in process for each visit, and**
- **Prescriptions. (*Note*: As a rule, VA HCFs cannot provide outpatient medications to patients, except for an emergent situation as required for an emergency room (ER) visit or inpatient care; however, VA HCFs can provide written prescription(s). Currently, there are only six sites that are allowed to participate in the TRICARE Pharmacy program.)**

***Reference*: For information on**
eligibility, see VHA.PG.1601D.01.2.2 (TBD)
bility, see VHA.PG.1601D.01.2.3 (TBD), and
benefits, see VHA.PG.1601D.01.2.4 (TBD)

TRICARE Billing Overview

Outpatient:
To identify billable TRICARE outpatient events, the Biller must review the *Bill Me Report* daily for all encounters that have insurance listed as TRICARE

Inpatient:
The Utilization Review (UR) Admission Bulletin notifies the members of the DGPM UR ADMISSION mail group when a patient with insurance is admitted.

TRICARE Billing Overview

-continuation

Third Party Billing staff: Creates the third party bill in VistA and transmits using electronic data interchange (EDI), and submits it to the applicable TRICARE MCSC

TRICARE: Processes the third party bill sends payment to VA, and returns an *Explanation of Benefit* (*EOB*) / Electronic Remittance Advice (ERA) to the VA HCF

Accounts Receivable (AR) staff: Reviews the *EOB* / ERA applies the necessary payments audits for any payment discrepancies, and forwards the *EOB* / ERA to the Biller

First Party Billing: Creates the first party bill for the deductible and cost share/copayment

AR staff: Monitors the TRICARE first party collections.

TRICARE Billing Overview

-continuation

Registration Insurance Screen

INSURANCE DATA, SCREEN <5>

[1] Covered by Health Insurance: YES

- INSURANCE COMPANY NAME: **TRICARE**
- GROUP NAME: **STANDARD, EXTRA, PRIME or TFL (TRICARE FOR LIFE)**
- TYPE OF PLAN: **TRICARE**
- WHOSE INSURANCE: **OTHER**
- ***SUBSCRIBER ID: SPONSOR ID #***
- NAME OF INSURED: **NAME OF TRICARE SPONSOR**
- ***INSURED'S SSN: SPONSOR'S SSN***

NOTE: Ask if the patient, spouse or sponsor has Other Health Insurance. (i.e., BLUE CROSS, AETNA, etc.) This information must be entered on Screen

TRICARE Billing Overview

-continuation

- **EFFECTIVE DATE: NOV 1,2005//**
- **EXPIRATION DATE: JUL 1,2007//**
- **WHOSE INSURANCE:SPOUSE//??**
  - **Enter 'v' if this insurance policy is held by the veteran, 's' if the veterans spouse holds the policy, or '0' if anyone else is the policy holder.**
- **Choose from:**
  - v **VETERAN**
  - s **SPOUSE**
  - 0 **OTHER**
- **WHOSE INSURANCE: SPOUSE//**
- **PT. RELATIONSHIP TO INSURED: SPOUSE//??**
  - **Enter the code which best describes the patient's relationship to the person who holds this policy (or insured).**
  - **\SPOUSE//**

TRICARE Billing – Third Party Billing

VA HCFs have the ability to generate claims for professional care on a CMS-1500, and institutional charges on a UB-04, using the appropriate revenue code series.

Exception: The above does *not* apply to community-based outpatient clinics (CBOCs) designated as non-provider based, who can only bill for professional fees using a CMS-1500.

Billing for TRICARE patients requires the correct billing *rates type* (for example, when generating a TRICARE claim, the TRICARE rate type must be used and the appropriate authorizations must be entered).

Important: Do *not* use reimbursable insurance for any TRICARE claims.

NC .E Reimbursable Insurance should ONLY be

.se

TRICARE Billing – First Party Billing

Create separate inpatient, outpatient, and appropriate pharmacy patient charges for the total first party deductible/cost share/copayment claim.

Note: Currently, only six sites may dispense and submit claims for Outpatient TRICARE pharmacy.

First party charges are *not* waiverable.

Use the TRICARE *EOB / ERA* to bill patients' first party debt (for example, cost share /copayment and deductible charges).

Rationale: The TRICARE *EOB / ERA* shows the dollar amount the patient owes VA for the episode of

TRICARE Billing – Rates

Use of reasonable charges for TRICARE bills is preferred

Task overview for loading the CHAMPUS Maximum Allowable Charge (CMAC) billing rates, including

- Task 1: accessing and downloading the CMAC billing rates, and
- Task 2: importing the CMAC billing rates in the Veterans Integrated Systems and Technology Architecture (VistA)

TRICARE allowable rates are

- Negotiated between local VA/ VISNs and the regional TRICARE Managed Care Support Contractor (MCSC)
- Contained in the agreement with the TRICARE MCSC, and

the TRICARE Fiscal Intermediary claims system.

EDI for TRICARE Claims

To ensure claims are transmitted electronically to TRICARE:

- Validate the Institutional and Professional Electronic Bill IDs in VistA against the ones indicated on the Emdeon website
  - The Electronic Bill ID is an Emdeon provided routing number that determines which payer they transmit your claims to
  - If the Electronic Bill ID fields are not populated with the correct Bill ID, the claims will not be transmitted electronically to the correct payer and will be printed to paper. Paper claims will be returned to your facility for a signature.

- Validate that the Electronic Transmit option is set to "YES-LIVE"

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EDI for TRICARE Claims

(continuation of previous slide)

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Insurance Company Information for: TRICARE

Type of Company: TRICARE Currently Active

Billing Parameters

Signature Required?: YES

Reimburse?: DEPENDS ON POLICY, CH

Mult. Bedsections: YES

Diff. Rev. Codes:

One Opt. Visit: NO

Amb. Sur. Rev. Code: 490

Rx Refill Rev. Code: 250

Filing Time Frame: 1 YEAR FROM DATE OF SERVICE

Type Of Coverage: TRICARE POLICY

Pr HCFA 1500

Billing Phone:

Verification Phone: 800 493-1613

Precert Comp. Name:

Precert Phone: 800 941-4501

*** EDI Parameters ***

Transmit?: YES-LIVE

Inst Payer ID: 61125

Prof Payer ID: 57106

Insurance Type: GROUP

Bin Number:

REFERENCES - TMA

TRICARE

- FACT SHEETS:
  - TRICARE Regional Contractor Information
  - TRICARE: The Basics
    - TRICARE: How Do I File A Claim
  - TRICARE For Life
  - TRICARE PLUS
  - Transitional Assistance Management Program (TAMP)
  - TRICARE Reserve Select Program – Tier 1, 2 and 3
  - TRICARE Mail Order Pharmacy
  - TRICARE: Skilled Nursing Facility & Long Term Care
  - [illegible]se Eligibility and Enrollment Reporting System [illegible]S)

Medical Sharing Revenue Source Codes

VHA Revenue Source Codes
8111 VA/ DoD & TRICARE Sharing (FY 2002)

RSC	Name	Responsible Office or Person	Definition and Usage
8028	**TRICARE - Inpatient Care**	**Medical Sharing Office**	**Medical services contracts for inpatient services (i.e., services which involve an overnight stay) negotiated with DoD's managed care contractors.**
8029	**TRICARE - Outpatient Care**	**Medical Sharing Office**	**Medical services contracts for outpatient services negotiated with DoD's managed care contractors; e.g., lab, physicals, etc.**
8030	**TRICARE - All Other**	**Medical Sharing Office**	**This code is used for first party co-pays and deductibles paid by TRICARE patients.**